

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-026072

DO NOT WRITE
ON THIS STUD

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **6833** STATE FILE NUMBER

FILED JUL 5 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION INCARNATE WORD HOSP		d. STREET ADDRESS (If outside, give location) 2003 VIRGINIA	
3. NAME OF DECEASED (Type or print) First Middle Last EDWARD KLINE		4. DATE OF DEATH Month Day Year JUNE 29 1963	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH FEB 20 1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED TEAMSTER		10b. KIND OF BUSINESS OR INDUSTRY	
11a. FATHER'S NAME UNKNOWN		11b. MOTHER'S MAIDEN NAME UNKNOWN	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) NO		13. SOCIAL SECURITY NO. ANNA WEBER 2003 VIRGINIA	
14. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 420.1 DUE TO (c)		15. INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
16. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	17a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	17b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
18a. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	18b. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
19. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 1960 to 1963 and last saw her/him alive on 6/29/63 Death occurred at 4 A m on the date stated above, and to the best of my knowledge, from the causes stated.		22. SIGNATURE (Degree or title) Ralph Berglund 22b. ADDRESS 3203 S Grand 22c. DATE SIGNED 6/29/63	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE JULY 1, 1963	23c. NAME OF CEMETERY OR CREMATORY ZION CEMETERY	23d. LOCATION (City, town, or county) (State) ST. LOUIS CO. MO.
24. GENERAL DIRECTOR ADDRESS Thomas Kutis 2906 Grannis		25. DATE RECD. BY LOCAL REG. JUL 1 1963	
26. REGISTRAR'S SIGNATURE Joan Smith, M.D.			

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT
BY AFFIDAVIT OF

VS 300
Rev. 4/59
1
2 **21**
3
4 **0**
5 **0**
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7 **0**
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12 **63-0**
13

63

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed J. G. Humphrey

Licensed Embalmer No. 4772

P. O. Address 2906 Graves

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

Dr. Ralph Berg
13203, 8th Avenue
P.O. 37857
12-44 St.